

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

4353 State File No. 21007

BIRTH NO. _____		REG. DIST. NO. <u>237</u>		PRIMARY REG. DIST. NO. <u>5020</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>New Madrid</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Gideon</u>		c. LENGTH OF STAY (in this place) <u>6 Yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Gideon</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>							
3. NAME OF DECEASED a. (First) <u>Elizabeth</u>		b. (Middle) <u>Ellen</u>		c. (Last) <u>Abshire</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-27-50</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Dec. 9- 1874</u>	
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Carrier Mills, Ill.</u>	
11. BIRTHPLACE (State or foreign country) <u>Carrier Mills, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Silas Abshire</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Merle Garrison</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>High Blood Pressure</u> DUE TO (c) <u>and Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3317</u>				INTERVAL BETWEEN ONSET AND DEATH. <u>8 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES ☐ NO ☐	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-18</u> , 19 <u>50</u> to <u>5-27</u> , 19 <u>50</u> that I last saw the deceased alive on <u>5-26</u> , 19 <u>50</u> and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.							
23a. SIGNATURE <u>St. C. Calkins D.O.</u> (Degree or title)				23b. ADDRESS <u>Malden Mo</u>		23c. DATE SIGNED <u>5/27/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-28-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Malden Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>2 Mi. No. Malden Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 7, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. Byrre Sharp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lloyd Russell Piggott</u>		ADDRESS <u>Ph.</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 12 1950

RECEIVED

District Health Office No. 2,

District File Number 650-231

Date Filed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.